

8664

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Fred.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
11 TOWN Frederick		3 yrs.		TOWN Rural Hope Hill		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS II8 East Street				STREET ADDRESS (If rural give location) Rural Hope Hill			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Cora Dillon Allen				Sept. 20 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		Colored		Widowed		Sept 1, 1976	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: yrs.		12. CITIZEN OF WHAT COUNTRY?	
Housewife		*****		79		Cookstown, New Jersey USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel Stout				Josephine Wilkenson			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
No		219-07-9510 A		Grant Allen-- II8 East Street			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 Immediate cause (a) CORONARY ARTERY sclerosis with DUE TO ACUTE MYOCARDIAL infarction							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized ARTERIOsclerosis DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from 10-16, 1953, to 9-20, 1955, that I last saw the deceased alive on 9-19, 1955, and that death occurred at 4 A.M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
R. R. Martin, M.D.				35E Church Frederick, Md.			
23. FUNERAL CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept 24, 1955		Fairview		Frederick, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 22, 1955		Frank R. Smith, Jr.		Charles E. Hicks III		Fred. Md.	

DEPUTY LOCAL REGISTRAR

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 28 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. *1*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <i>Rural - Mt. Airy</i>		<i>6 months</i>		TOWN <i>Rural - Mt. Airy</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Route 1 - Sidney Road</i>				STREET ADDRESS (If rural give location) <i>Route 1 Sidney Road</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
(First) <i>Henry</i> (Middle) <i>Charles</i> (Last) <i>Bennett</i>				DEATH: <i>Sept. 8 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>		8. DATE OF BIRTH: <i>March 20, 1890</i>	
				9. AGE last birthday <i>65</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Laborer</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
						12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Abraham Bennett</i>				14. MOTHER'S MAIDEN NAME: <i>Grace Young</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>1226 W. Saratoga Baltimore, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Luetic Aortitis</i>						<i>Unknown</i>	
ANTECEDENT CAUSE (B) <i>Syphilis with Decomensation</i>						<i>Unknown</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 30, 1955</i> , to <i>Sept. 8, 1955</i> , that I last saw the deceased alive on <i>Aug. 24, 1955</i> , and that death occurred at <i>5:15 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>W.B. Culwell</i>				ADDRESS <i>Mt. Airy, Md.</i>		DATE SIGNED <i>Sept 8, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9-11-1955</i>		<i>Bushey Park</i>		<i>Howard Co. Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Sept. 9, 1955</i>		<i>Blairie A. Runkles</i>		<i>C.M. Waltz</i>		<i>Winfield, Md.</i>	

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 13 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8665		Item 21a Film 186 8-12-55 et		08672	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 131					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Va.</i> COUNTY <i>Fairfax</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>McLean</i> <i>83X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Removed to Frederick Memorial Hosp. Dead on arrival</i>				STREET ADDRESS (If rural, give location) <i>Emerson Street</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<i>Willard Justin Breckenridge</i>			<i>Sept. 11 1955</i>		
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>1/8/1921</i>	9. AGE last birthday: <i>34</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Officer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>US Park Police</i>		11. BIRTHPLACE (State or foreign country): <i>Loudoun County, Va.</i>	
13. FATHER'S NAME: <i>Charles C. Breckenridge</i>			14. MOTHER'S MAIDEN NAME: <i>Hazel Herrell</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.: <i>no</i>		17. INFORMANT & ADDRESS: <i>Charles V. Breckenridge Laughlin Avenue, McLean, Virginia</i>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					<i>950</i>
Immediate cause (a) <i>Broken neck</i>					<i>10 minutes</i>
DUE TO					
Antecedent cause(s) (b)					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>Automobile accident</i>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Highway</i>		21c. (City or town) (County) (State) <i>near Shannont Frederick Md</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>9 11 1955 935 M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Auto ran off road & struck a tree</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>B.D. Thomas</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> DATE SIGNED <i>9/11/55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>burial</i>		DATE THEREOF: <i>9-14-55</i>		NAME OF CEMETERY OR CREMATORY: <i>Nat. Mem. Park Cem.</i>	
LOCATION (City, town, or county) (State): <i>Falls Church - Va.</i>		24. FUNERAL DIRECTOR: <i>A. H. James Co.</i>		ADDRESS: <i>2901 14th NW. Wash. D.C.</i>	
DATE REC'D BY LOCAL REG. <i>13 Sept. 1955</i>		REGISTRAR'S SIGNATURE: <i>Elizabeth L. Heck</i>			

BUREAU V. S.

SEP 14 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 13

87-2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Burkittsville</i>		<i>life</i>		TOWN <i>Burkittsville</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>/</i>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) <i>Robert Lee Brown</i>				OF DEATH: <i>9 3 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>male</i>	<i>white</i>		<i>5-17-1955</i>	yrs. <i>3</i>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Herbert Grim</i>				<i>Betty L. Brown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>1 -</i>				<i>-</i>		<i>Betty Brown</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
421.4 IMMEDIATE CAUSE (A) <i>Endocardial Sclerosis</i>						<i>Audden</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<i>0</i>		<i>-</i>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July</i> , 19 <i>55</i> to <i>Sept 3</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Aug. 16</i> , 19 <i>55</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J E Harp</i>		M. D. <i>Middleton</i>		DATE SIGNED <i>9-3-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<i>Burial</i>		<i>9-4-1955</i>		<i>Elizabeth V. Hersh</i>		<i>Leadhill Co., Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

RECEIVED

SEP 7 1955

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

08674

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

8703

1. PLACE OF DEATH - COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY Maryland		Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5		LENGTH OF STAY Years		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R. D. #5			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Edgemont				STREET ADDRESS Edgemont			
3. NAME OF DECEASED (First) LUCY		(Middle) KATE		(Last) BRUST		4. DATE OF DEATH (Month) (Day) (Year) September 16, 1955	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Oct. 28, 1876	
				9. AGE last birthday 78 yrs.		10. If under 1 year (Month) (Day) (Hour) (Min.) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin H. Davis				14. MOTHER'S MAIDEN NAME Rebecca Coblentz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS Mr. B. A. H. Brust, Frederick R.D.#5, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) Strangulation by hanging						seconds	
Immediate cause							
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) Home		(CITY OR TOWN) Frederick R.D. 5		(COUNTY) (STATE) Frederick Md	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work [] Not while at work []		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy [], Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [] accident [] suicide <input checked="" type="checkbox"/> , homicide [], undetermined [].							
SIGNATURE B. A. H. Brust		(Degree or title) Dep. Med. Exam.,		ADDRESS Frederick, Maryland		DATE SIGNED 9/17/1955	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Sept. 18, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REG. 17 Sept 1955		REGISTRAR'S SIGNATURE Elizabeth B. Heck		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 20 1955

RECEIVED

8666

08675

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 131

1. PLACE OF DEATH: <i>Frederick Memorial Hospital</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>11 Frederick</i>	LENGTH OF STAY (in this place)	CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Mt. Airy-Rural-R. D.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Memorial Hospital, Frederick, Md</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <i>John</i> (Middle) (Last) <i>Burns</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>September 12, 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>E</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widower</i>	8. DATE OF BIRTH: <i>1874 ?</i>
9. AGE last birthday: <i>80?</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Laborer</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME: <i>Charles Burns</i>	
14. MOTHER'S MAIDEN NAME: <i>Mary Hopkins</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY No.: <i>219-03-2682</i>		17. INFORMANT & ADDRESS: <i>Carl Anderson, Mt. Airy, R.D., Maryland</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>Fracture base of Skull</i>			<i>7 hrs.</i>
DUE TO			
Antecedent cause(s) (b) <i>Struck by automobile</i>			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>Struck by automobile</i>			
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Frederick, Md</i>	21c. (City or town) (County) (State) <i>Route 40 Howard Md</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>9 11 1955 7 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Struck by automobile</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>John B. Burns</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Sept 12-55</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>Sept. 14, 1955</i>	NAME OF CEMETERY OR CREMATORY: <i>Friendship Cemetery</i>	LOCATION (City, town, or county) (State): <i>Carroll County, Maryland</i>
DATE REC'D BY LOCAL REG. <i>Sept. 12, 1955</i>	REGISTRAR'S SIGNATURE: <i>Elizabeth G. Herb</i>	24. FUNERAL DIRECTOR ADDRESS: <i>C. M. Walsh Funeral Home, Winfield, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 3 1900

12 1900

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08676

8667

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Fred.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> LENGTH OF STAY (in this place) <u>10</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hospital - West Frederick</u>		STREET ADDRESS (If rural, give location) <u>West 13</u>	
3. NAME OF DECEASED (Type or Print) <u>William R. BUSSARD</u>		4. DATE OF DEATH (Month) <u>9</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-11-1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>46</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert L. Bussard</u>		14. MOTHER'S MAIDEN NAME <u>Grace Bean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT <u>R. L. Bussard Brunswick Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>148X</u> <u>Leucemia throat</u>		<u>34 yr</u>
(b) Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY		

22. I hereby certify that I attended the deceased from....., 1952, to Sept 24 1955, that I last saw the deceased alive on Sept 24, 1955, and that death occurred at 4 P m. from the causes and on the date stated above.

SIGNATURE H. K. Keene M.D. ADDRESS Fredrick Md DATE SIGNED Sept 26 55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>9-28-55</u>	<u>Stark Heights</u>	<u>Brunswick</u>	<u>Md</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>26 Sept. 1955</u>	<u>Elizabeth B. Hersh</u>	<u>C. A. Zeit + Co</u>	<u>Brunswick Md</u>	

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08677

8668

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FREDERICK</u>		<u>5 Weeks</u>		TOWN <u>Frederick Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>THREE PINES Nursing Home</u>				STREET ADDRESS (If rural give location) <u>505 Magnolia Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>PRISCILLA</u> (First) <u>COMP</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 23</u> 19 <u>55</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>11 OCT 1885</u>		9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis, left middle cerebral artery</u>		DUE TO		<u>one month</u>			
ANTECEDENT CAUSE(S) (B) <u>Cerebral Arteriosclerosis</u>		DUE TO		<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized Arteriosclerosis</u>		DUE TO		<u>1 year</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>23 Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>23 Sept</u> , 19 <u>55</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas E Stone</u> M.D.				ADDRESS (Street, city, town, state) <u>4 W 3rd St</u>		DATE SIGNED <u>9-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Phelos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westport Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Frank R. Smith Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u>		ADDRESS <u>Westport Md</u>	
DATE <u>9/23/55</u>		Dep. Registrar		By P.D.			



CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Middletown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Middletown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Alice F DAVIDSON</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>9 16 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>2-15-1861</u>	
9a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>nurse</u>				9b. KIND OF BUSINESS OR INDUSTRY: <u>Practical nursing</u>		9. AGE last birthday: <u>94</u> yrs. Months Days Hours Min.	
10a. FEMALE OCCUPATION Give kind of work done during most of working life, even if retired: <u>nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Practical nursing</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>John W. Davidson</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Snook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Clarence Bussard Frederick-Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Acute Coronary Thrombosis</u>							
Antecedent causes (s) (b) <u>Arteriosclerosis, generalized</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 16, 1955</u> to <u>Sept 16, 1955</u> , that I last saw the deceased alive on <u>Sept 15, 1955</u> , and that death occurred at <u>4:45 P</u> from the causes and on the date stated above.							
SIGNATURE <u>Janet C. Benson, M.D.</u>				DATE SIGNED <u>Sept 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>19 Sept 1955</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>19 Sept 1955</u>		<u>Frank R. Smith, Jr.</u>		<u>C. E. Cline & Son</u>		<u>Frederick Md</u>	

S. A. G. 1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

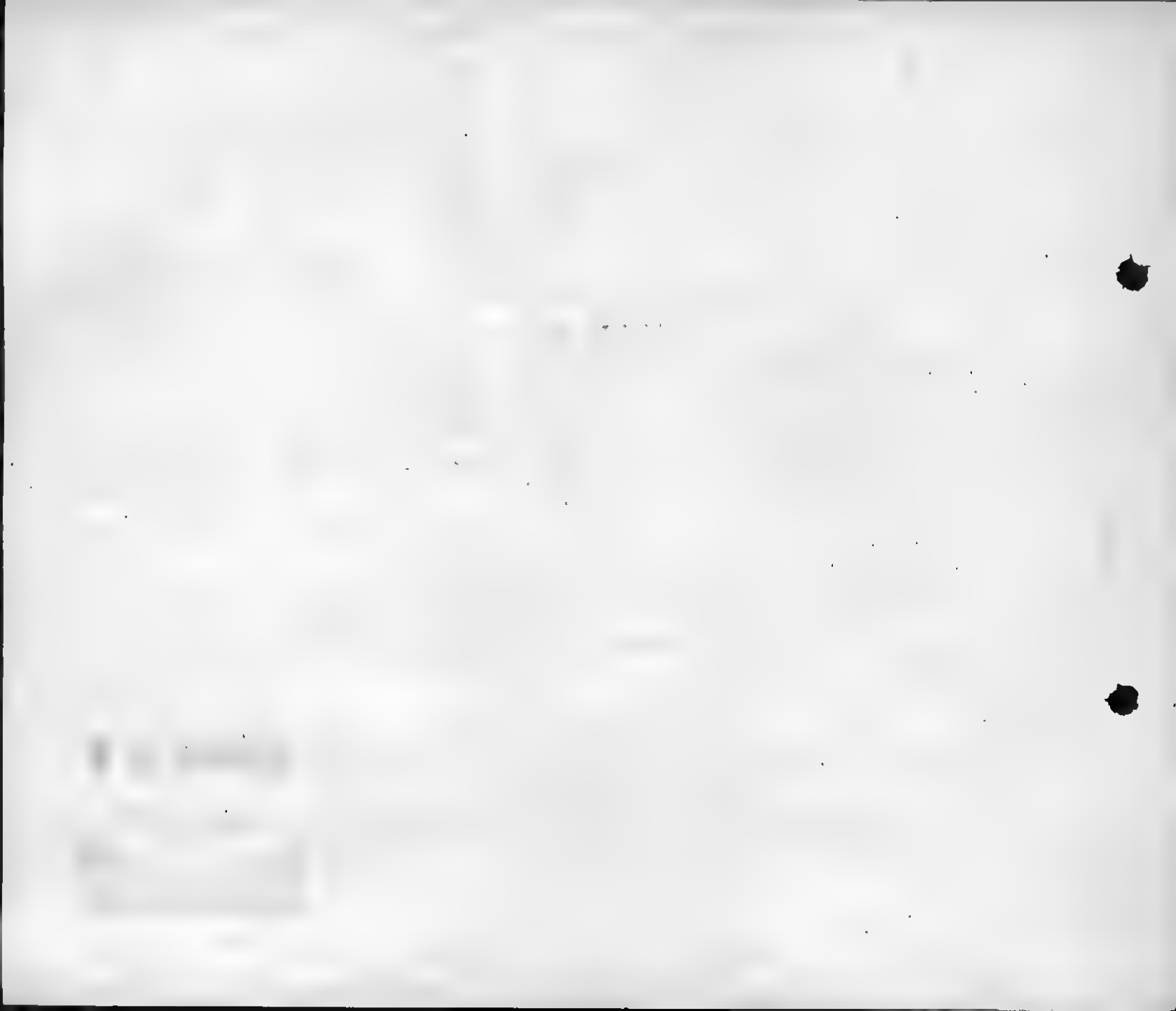
08679

87-15

CERTIFICATE OF DEATH

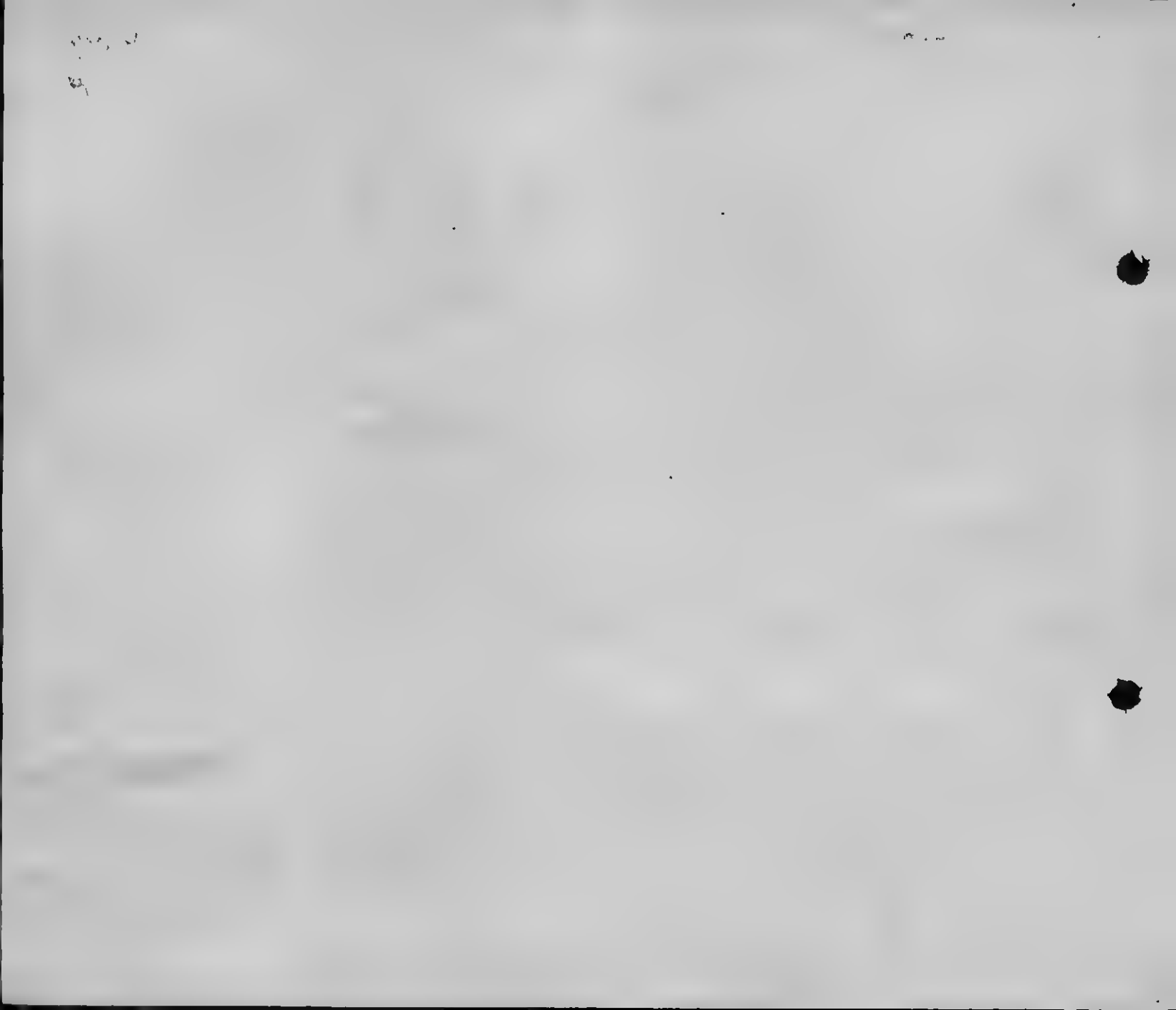
Reg. Dist. No. 144

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Fredrick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Fredrick</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Rural-- Thurmont</u>		<u>Lifetime</u>		TOWN <u>Rural-- Thurmont</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				/			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>HOWARD CALVIN DAVIS</u>				OF DEATH: <u>Sept. 9 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 25 1900</u>	<u>55</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Forman P.E. Railroad</u>				<u>Maintenance</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>McClellan Davis</u>				<u>Sarah Yingling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:	
<u>No</u>				<u>214-10-5883</u>		<u>Mr. Ralph Scruton Thurmont (rural)</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4341 IMMEDIATE CAUSE				(A) <u>Heart disease, congestive - it is</u>			
ANTECEDENT CAUSE (B):				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
X							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 1955</u> to <u>Sept 9, 1955</u> that I last saw the deceased alive on <u>Sept-3, 1955</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
				<u>Thurmont, Md.</u>		<u>7-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>Sept. 12</u>		<u>Blue Ridge Cemetery</u>	
						<u>Thurmont, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Sept. 12, 1955</u>				<u>Blanche S. Eyles</u>		<u>M. L. Creager & Son Thurmont, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2716 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				08680 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 131					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Dickerson, Md.</u>	
TOWN <u>Near Dickerson</u>				STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Dickerson</u>					
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>William Robert Liggett</u>			<u>Sept. 17 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1-6-1902</u>	9. AGE last birthday: <u>53</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B & O. R.R.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Robert Liggett</u>			14. MOTHER'S MAIDEN NAME: <u>Laura Davis</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Gun shot wound below left</u>					<u>15 minutes</u> ?
DUE TO					
Antecedent cause(s) (b) <u>apical protruding left lung & heart</u>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause DUE TO (c) <u>heart</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Near Dickerson</u>		21c. (City or town) (County) (State) <u>Dickerson Frederick Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9 17 1955</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>3. J. S. ...</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>9/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Portersville</u> LOCATION City, town, or county (State) <u>Portersville Md.</u>	
DATE REC'D BY LOCAL REG. <u>9/21/55</u>		REGISTERAR'S SIGNATURE <u>Elizabeth S. Zecher</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8659

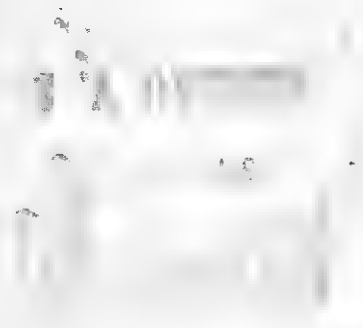
CERTIFICATE OF DEATH

Reg. Dist. No.

08681

B1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR <u>Town</u>				OR <u>Town</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Frederick Memorial Hospital</u>				<u>W. Main</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Missouri</u>				<u>Sept 13 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>Sept 13 1901</u>	
9. AGE last birthday: <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John P. Missouri</u>				14. MOTHER'S MAIDEN NAME: <u>John P. Missouri</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>			
17. INFORMANT & ADDRESS: <u>John P. Missouri</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
904.0 IMMEDIATE CAUSE							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <u>Shock</u>							
DUE TO							
(B) <u>Fracture Hip</u>							
DUE TO							
(C) <u>Accidental Fall</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Sept 13 5:55 PM</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>Fall at home</u>			
22. I hereby certify that I attended the deceased from <u>Sept 13, 1955</u> , to <u>Sept 13, 1955</u> , that I last saw the deceased alive on <u>Sept 13, 1955</u> , and that death occurred at <u>1230 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. P. Thomas</u>		M. D.		DATE SIGNED <u>Sept 18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Removal</u>		<u>Sept 13, 1955</u>		<u>Frederick Memorial Hospital</u>		<u>Frederick, MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept 13, 1955</u>		<u>Elizabeth S. Heck</u>		<u>Frederick Memorial Hospital</u>		<u>Frederick, MD</u>	



8670

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>FREDERICK</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN FREDERICK</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Woodsboro</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 FREDERICK MEMORIAL</u>	HOSPITAL	STREET ADDRESS (If rural give location) <u>RT #1</u>	1
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>EVELYN</u>	(Middle) <u>MARIE</u>	(Last) <u>FOGLE</u>	DATE OF DEATH: <u>SEPT 25 1955</u>
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Infant.</u>	8. DATE OF BIRTH: <u>SEPT 22, 1955</u>
9. AGE last birthday <u>3</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Ind.</u>	11. CITIZEN OF WHAT COUNTRY? <u>Ind.</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		13. FATHER'S NAME: <u>MAX RAY FOGLE</u>	
14. MOTHER'S MAIDEN NAME: <u>MARY JANE WOLFE</u>		15. INFORMANT & ADDRESS: <u>Mother - Mrs. MAX FOGLE - Woodsboro Maryland</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		17. SOCIAL SECURITY NO. <u>no</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)		DUE TO <u>Anecephalus</u>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/22, 1955</u> to <u>9/25, 1955</u> that I last saw the deceased alive on <u>9/24, 1955</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Hannu Ina</u>		DATE SIGNED <u>9-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>26-1955</u>	
NAME OF CEMETERY OR CREMATOR <u>Mt Hope Cem</u>		LOCATION (City, town, or county) <u>Woodsboro Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>26 Sept. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	
24. FUNERAL DIRECTOR <u>M. E. Regan</u>		ADDRESS <u>Thurmont Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED A. S.

SEP

1951

28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08683

8671

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		LENGTH OF STAY (in this place) 1 week		CITY (If outside corporate limits, write RURAL and give nearest town) Thurmont			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Three Pines Nursing Home				STREET ADDRESS (If rural give location) Thurmont			
3. NAME OF DECEASED: (Type or Print)		(First) George		(Middle) Baker		(Last) Fout	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED: Single		8. DATE OF BIRTH: April 3. 1868	
9. AGE last birthday 87 yrs.		10. MONTHS Sept.		11. DAY 26		12. YEAR 1955	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work		10B. KIND OF BUSINESS OR INDUSTRY: Hotels		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: George Fout				14. MOTHER'S MAIDEN NAME: Lucretia Shook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-16-1080		17. INFORMANT & ADDRESS: Mrs Amy Munshour Thurmont MD			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) cerebral thrombosis						2 days	
ANTECEDENT CAUSE (B) hypertension						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) none							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: none		19B. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 11, 1954 to Sept 26 1954 that I last saw the deceased alive on Sept 11, 1954 and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial		DATE THEREOF Sept. 28. 1955		NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.		LOCATION (City, town, or county) (State) Frederick. md	
DATE REC'D BY LOCAL REGISTRAR 27 Sept. 1955		REGISTRAR'S SIGNATURE Elizabeth G. Heck		24 FUNERAL DIRECTOR M.L. Creager & Son.		ADDRESS Thurmont md	

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL. 60637

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8707

CERTIFICATE OF DEATH

Reg. Dist. No. 1134

18684

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Emmitsburg		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Emmitsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last) Harry Robert Gelwicks				4. DATE (Month) (Day) (Year) OF DEATH: Sept 29th. 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, W DOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: June 17. 1877	9. AGE last birthday: 78 yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Emmitsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: George Gelwicks				14. MOTHER'S MAIDEN NAME: Barbara Gelwicks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO. 213-12-7845		17. INFORMANT & ADDRESS: Marie F. Gelwicks Emmitsburg Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of Prostate with metastases to pelvis						7 year	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/31 , 1955, to 9/29 , 1955, that I last saw the deceased alive on 9/29 , 1955, and that death occurred at 10:45 P.M. from the causes and on the date stated above.							
SIGNATURE Charles R. Williams		M. D. Emmitsburg Md		DATE SIGNED Sept 30 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 3. 1955		NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		LOCATION (City, town, or county) (State) Emmitsburg Fredk. Co. MD	
DATE REC'D BY LOCAL REGISTRAR Oct 2 1955		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR M. L. Creager & Son		ADDRESS Thurmont. MD	

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8708

CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> <u>Rural Middletown</u>		<u>2 yrs.</u>		<u>Rural Middletown</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Sydnor Claude Gordon</u>				DEATH: <u>9</u> <u>10</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>5-18-1894</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>farm tenant</u>		<u>farm</u>		<u>Virginia</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Benjamin Gordon</u>				<u>Barbara MacDonald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>17</u>				<u>219-20-0284</u>			
17. INFORMANT & ADDRESS:				<u>Mrs. Avery Gordon, Middletown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
422.1 IMMEDIATE CAUSE				<u>15 min</u>			
(A) <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE (S)							
(B) <u>Arterio-Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-10-1955</u> , to <u>9-10-1955</u> , that I last saw the deceased alive on <u>9-10-1955</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Middletown</u>		DATE SIGNED <u>9-10-55</u>	
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-13-1955</u>		<u>Edge Hill Cemetery</u>		<u>Charlestown, St. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9-12-55</u>		<u>Elizabeth B. Hack</u>		<u>Gladiol Co., Middletown, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8672

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 No. 8686
131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick	LENGTH OF STAY (in this place) 20 years	CITY (If outside corporate limits write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural, give location) 431-A West South Street	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) WILLIAM	(Middle) JOSEPH	(Last) GOUKER	(Month) September 26 (Day) 19 (Year) 55
6. SEX: Male	6. RACE OR COLOR: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: March 7, 1921
9. AGE last birthday: 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Machinist	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William I. Gouker		14. MOTHER'S MAIDEN NAME: Clara R. Zimmerman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY No: 214-10-3822	
17. INFORMANT & ADDRESS: Mrs. William J. Gouker - Frederick, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		3 days
Immediate cause (a) ... <i>Fractured lower with laceration</i> Antecedent cause(s) (b) ... <i>Infant pneumonia</i> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) ... <i>Disseminated intravascular coagulation</i>		
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 9/25/55		19b. MAJOR FINDING OF OPERATION: <i>Fractured lower with laceration</i>
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Frederick</i>
21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR? <i>Automobile under truck trailer</i>
21e. TIME (Month) (Day) (Year) (Hour) OF INJURY: 9/23/55 8:25 M.		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE: <i>Blanche</i>		DATE SIGNED: <i>Sept. 28, 1955</i>
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: Sept. 28, 1955
NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery		LOCATION (City, town, or county) (State): Frederick, Maryland
DATE REC'D BY LOCAL REG.: 28 Sept. 1955		24. FUNERAL DIRECTOR: C. E. Cline & Son - Frederick, Maryland

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

235

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08687

8673

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town.) <i>Frederick</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town.) <i>Rural Myersville</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred. Memorial Hospital</i>		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Dolly R. Green</i>		OF DEATH: <i>9 8 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>	8. DATE OF BIRTH: <i>1-8-1894</i>
9. AGE last birthday: <i>61</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. BIRTHPLACE (State or foreign country): <i>Pa.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>			
13. FATHER'S NAME: <i>John Hurd</i>		14. MOTHER'S MAIDEN NAME: <i>Isabella</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No. <i>none</i>	
17. INFORMANT & ADDRESS: <i>Chester Green, Myersville, Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <i>Acute Coronary Occlusion</i>			<i>10 min</i>
ANTECEDENT CAUSE (B) <i>Coronary artery disease</i>			<i>2-3 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>arteriosclerosis generalized</i>			<i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/21</i> , 19 <i>55</i> , to <i>9/7</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9/7</i> , 19 <i>55</i> , and that death occurred at <i>5:50A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Frederick A. Skenson</i>		DATE SIGNED <i>9/8/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-10-1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Pleasant Walk U.B.Cem.</i>		LOCATION (City, town, or county) (State) <i>Frederick Co, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9-9-1955</i>		24. FUNERAL DIRECTOR ADDRESS <i>Gladhill Co. Middletown, Md.</i>	
REGISTRAR'S SIGNATURE <i>Elizabeth B. Hack</i>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8674

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08688

131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick MARYLAND		STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 47 East Third Street		STREET ADDRESS (If rural give location) 47 East Third Street	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
GORDON LOY GREENAWALT		September 18, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH June 8, 1902
9. AGE last birthday 53 yrs.		10. BIRTHPLACE (State or foreign country): West Virginia	
11. BIRTHPLACE (State or foreign country): West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George W. Greenawalt		14. MOTHER'S MAIDEN NAME: Josephine Lough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 217-18-7715	
17. INFORMANT & ADDRESS: 47 East Third Street, Mrs. Helen K. Greenawalt, Frederick, Maryland			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cerebral Thrombosis with hemiplegia, right side		6 wks.	
ANTECEDENT CAUSE (B) Arteriosclerotic Cardiovascular disease		2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 3, 1955 , to Sept 18, 1955 , that I last saw the deceased alive on Sept 16, 1955 , and that death occurred at 6:00 AM , from the causes and on the date stated above.			
SIGNATURE Henry V. Chase		DATE SIGNED 9/19/1955	
ADDRESS Frederick, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 21, 1955	
NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Kline, Pendleton Co., W. Virginia	
DATE REC'D BY LOCAL REGISTRAR 20 Sept 1955		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland	

RECEIVED

NOV 19 1955

11/19/55

8675

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>136 W. Patrick St.</u>				STATE <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> STREET ADDRESS (If rural give location) <u>136 W. Patrick St.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>ANNA</u> (Middle) <u>BELL</u> (Last) <u>HOFF</u> (Type or Print)				(Month) <u>Sept</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>female</u>		<u>white</u>		<u>widow</u>		<u>5/29/1867</u>	
9a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired.				9b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>housewife</u>				<u>at home</u>		<u>88</u> yrs. Months Days Hours Min.	
10a. CITIZENSHIP				10b. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.</u>				<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Amos Muntzer</u>				<u>Henrietta Martin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>Essie J. Mull, Frederick, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>arterio-sclerotic heart disease</u> Antecedent causes (s) (b) <u>Generalized arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?							
Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 1953, to <u>Sept 2</u> , 1955, that I last saw the deceased alive on <u>Sept 2</u> , 1955, and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>Robt Martin M.D.</u>				<u>35 E Church Frederick Md.</u>		<u>9-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>9/5/55</u>		<u>Beaver Dam Cem. Thruway Bridge</u>		<u>Rural</u>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept 3/55</u>		<u>Elizabeth H. Heck</u>		<u>Powell & Hartzler</u>		<u>Woodboro, Ind</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 7 1967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08690

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <i>Knoxville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		—		STREET ADDRESS		—	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Mildred Louise Huffer</i>				<i>9 21 19 55</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>6-3-1902</i>	9. AGE last birthday: <i>53</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Joseph A. Swope</i>				14. MOTHER'S MAIDEN NAME: <i>Meliah Virts</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>Paul R. Huffer, Knoxville, Maryland</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
580X Immediate cause (a) DUE TO <i>Death yellow atrophy pharynx</i>						<i>14 hrs.</i>	
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>9-24-55</i>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6</i>, 19 <i>55</i> ., to <i>9-21</i> ., 19 <i>55</i> ., that I last saw the deceased alive on <i>9-21</i> ., 19 <i>55</i> ., and that death occurred at <i>8:11 p.m.</i> , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				DATE SIGNED <i>9-23-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>9-24-55</i>		NAME OF CEMETERY OR CREMATORY: <i>Reformed</i>		LOCATION (City, town, or county) (State): <i>Knoxville Maryland</i>	
DATE REC'D BY LOCAL REG: <i>Sept 23-55</i>		REGISTRAR'S SIGNATURE: <i>Kathryn N. Brown</i>		24. FUNERAL DIRECTOR: <i>C. H. Felt & Co Brunswick Md.</i>			

1871

8576

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>FREDERICK</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FREDERICK</u>		LENGTH OF STAY (in this place) <u>13 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FREDERICK, Maryland 11</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FREDERICK MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>244 West 5th Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>TONIS LOUISE JAMES</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9 17 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>16 Sept 55</u>	9. AGE last birthday: <u>13</u> yrs	10. UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>FREDERICK, Maryland</u>	
13. FATHER'S NAME: <u>Robert James, Jr.</u>				14. MOTHER'S MAIDEN NAME: <u>SARA LOUISE SIMPSON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):				19. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
16. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Adrenal Cortical Hemorrhage</u>						<u>10 hours</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>11/17/55</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>16 Sept</u> , 19 <u>55</u> , to <u>17 Sept</u> 19 <u>55</u> —that I last saw the deceased alive on <u>17 Sept</u> , 19 <u>55</u> , and that death occurred at <u>11:55 A</u> M, from the causes and on the date stated above.							
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-19-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>19 Sept 1955</u>		REGISTRAR'S SIGNATURE <u>Frank R. Smith, Jr.</u>		24. FUNERAL DIRECTOR <u>C.E. Cline & Son - Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. GOVERNMENT

PRINTING OFFICE

WASHINGTON, D. C.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08692

CERTIFICATE OF DEATH

Reg. Dist. No. 131

Ite 8677
m 8, Film G186 9-16-55 et

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>101 E 2nd ST</u>		STREET ADDRESS (If rural, give location) <u>101 East 2nd ST</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>Louise</u> (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) <u>9</u> (Day) <u>2</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1914/11/25</u> - 29 - 78 3 yrs.
9. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>H. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Laura Brashers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>Family Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>422.2 Immediate cause (a) <u>Myocarditis</u></p> <p>Antecedent cause(s) (b) <u>Cerebral Hemorrhage</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u></p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY		

22. I hereby certify that I attended the deceased from May 53, 19....., to Sept 2/55, that I last saw the deceased alive on Sept 2/55, 19....., and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE EP Thomas (Degree or title) ADDRESS Frederick MD DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>9/4/55</u>	<u>Frederick</u>	<u>Frederick</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3 Sept. 1955</u>	<u>Elizabeth B. Heck</u>	<u>H E Campbell</u>	<u>Frederick MD</u>	

BUREAU V. S.

SEP 7 1944

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 131

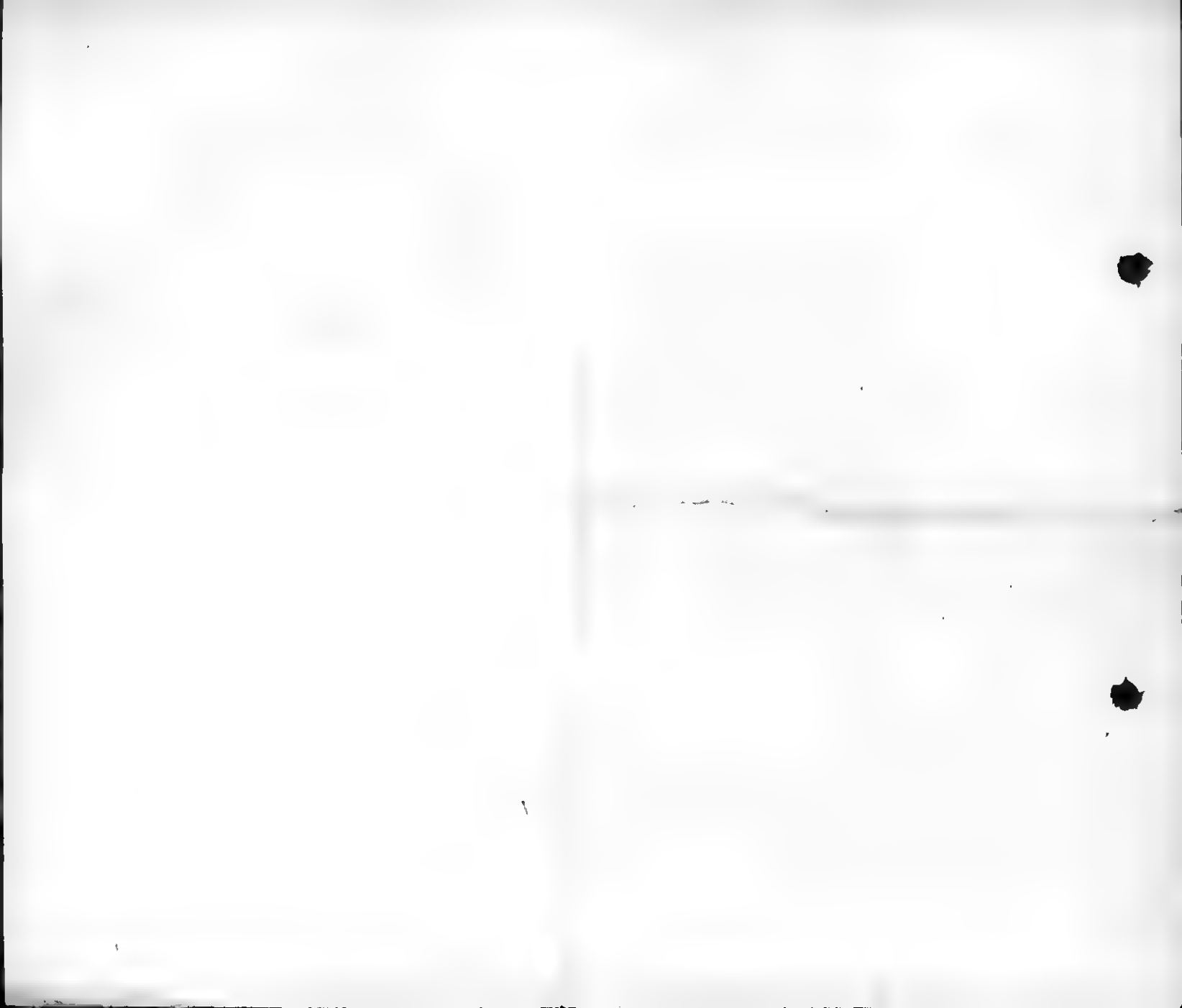
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>MARYLAND</u> <u>FREDERICK</u>			STATE <u>MARYLAND</u> COUNTY <u>1</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FREDERICK</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FREDERICK</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>506 W. 2ND STREET</u>			STREET ADDRESS (If rural give location) <u>506 W. 2ND STREET</u>		
3. NAME OF DECEASED: (First) <u>Harry</u> (Middle) <u>MORTON</u> (Last) <u>Kessler</u>			4. DATE OF DEATH: (Month) <u>Sept</u> (Day) <u>19</u> (Year) <u>1955</u>		
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 25, 1909</u>
9. AGE last birthday: <u>45</u> yrs.		10. MONTHS: <u>19</u>		11. DAYS: <u>19</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>HARRY KESSLER</u>		14. MOTHER'S MAIDEN NAME: <u>STELLA COHEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>FREDERICK, MD.</u> <u>Mrs. Kay Kessler - 506 W. 2ND STREET</u>	

18. MEDICAL CERTIFICATION			Interval Between Onset And Death		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>Carcinoma of esophagus</u>			<u>6 Months</u>		
Antecedent causes (s) (b) <u>DUE TO</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>May 28, 1955</u>			19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of esophagus</u>		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 18, 1955</u> , to <u>Sept 19, 1955</u> , that I last saw the deceased alive on <u>Sept 19, 1955</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.					
SIGNATURE <u>S. R. Schachman M.D.</u>		ADDRESS <u>228 N. Market St. Frederick</u>		DATE SIGNED <u>9-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>SEPT. 21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>	
LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		DATE REC'D BY LOCAL REGISTRAR <u>9-20-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>1124-267 North</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Town		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Town	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital		STREET ADDRESS Camp Detrick - nr. Frederick	
3. NAME OF DECEASED (First) CAROLINE (Middle) SOMMER (Last) KRICHBAUM		4. DATE OF DEATH (Month) September (Day) 28 (Year) 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 12, 1865
9. AGE last birthday 90 yrs.		10. BIRTHPLACE (State or foreign country) Indiana	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Sommer		14. MOTHER'S MAIDEN NAME Regina Sickenberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT Dr. Carroll E. Krichbaum - Camp Detrick		18. MEDICAL CERTIFICATION Frederick, Md.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
Immediate cause (a)...		Interval between onset and death	
Antecedent cause(s) (b)...			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)...			
19. DATE OF OPERATION		20. AUTOPSY?	
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		22. I hereby certify that I attended the deceased from 9/27/55, 1955, to 9/28/55, 1955, that I last saw the deceased alive on 9/28/55, 1955, and that death occurred at 8:40 a.m., from the causes and on the date stated above.	
TIME (Month) (Day) (Year) (Hour) OF INJURY Sept 27 '55 2 a.m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? Fall out of bed		DATE SIGNED 9/28/55	

23. BURIAL, CREMATION (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
Removal Sept. 30, 1955 J. William Lee's Sons Co. Washington, D. C.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 30 Sept. 1955 Elizabeth G. Heck	
24. FUNERAL DIRECTOR ADDRESS C. E. Cline & Son - Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. DEPARTMENT OF JUSTICE

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8679

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) Frederick HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) Frederick STREET ADDRESS (If rural, give location) 62 Taney Apts.	
3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) RAY	(Last) LONG
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 16, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Tech.		10b. KIND OF BUSINESS OR INDUSTRY Army Chem. Post	9. AGE last birthday 29 yrs. September 15, 1955
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Long, Sr.		14. MOTHER'S MAIDEN NAME Violet Ray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or service) WWII		16. SOCIAL SECURITY No. 219-07-2128	
17. INFORMANT AND ADDRESS Mrs. Deloris F. Long, 62 Taney Apts., Frederick, Maryland			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(a) *Bullet wound right side of skull and back of ear -*

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY *Home*

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Gunshot Wound at Right Temple

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy .. Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, or other disposal (Specify) **Burial**

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

17 Sept. 1955*Elizabeth H. Hech***M. R. Etchison & Son, Frederick, Maryland****Dep. Med. Exam., Frederick, Maryland****9/16/1955****Sept. 18, 1955****Mount Olivet Cemetery****Frederick, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

RECEIVED

NOV 10 1964

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY Fredrick MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Buckhillsville LENGTH OF STAY (in this place) Life
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Fredrick
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Buckhillsville
 STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED:

(First) Blanche (Middle) M. (Last) Mahoney
 (Type or Print)

4. DATE OF DEATH: (Month) 9 (Day) 24 (Year) 1955

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Single

8. DATE OF BIRTH:

6-24-1870

9. AGE last birthday:

85 yrs.

IF UNDER 1 YEAR Months Days Hours Min.
 IF UNDER 24 HRS

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

None

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME:

John H. Abolt

14. MOTHER'S MAIDEN NAME:

Hanutt James W. Wallard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Wm C W Miller, Knoxville Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

714X
Immediate cause

(a) Semibility
 DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) —
 DUE TO

(c) —

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death
5 yrs.

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23-1955, to 9-24-1955, that I last saw the deceased

alive on 9-23-1955, and that death occurred at 4:30 pm from the causes and on the date stated above.

SIGNATURE [Signature]

(Degree or title) MD

ADDRESS Brownsville, Md

DATE SIGNED 9-26-55

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

9-24-55

NAME OF CEMETERY OR CREMATORY

Union

LOCATION (City, town, or county)

Buckhillsville Md

DATE REC'D BY LOCAL REGISTRAR 30 Sept. 1955

REGISTRAR'S SIGNATURE

Elizabeth B. Heck

24. FUNERAL DIRECTOR

E. H. Felt + Bro Baltimore Md

ADDRESS

Baltimore Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

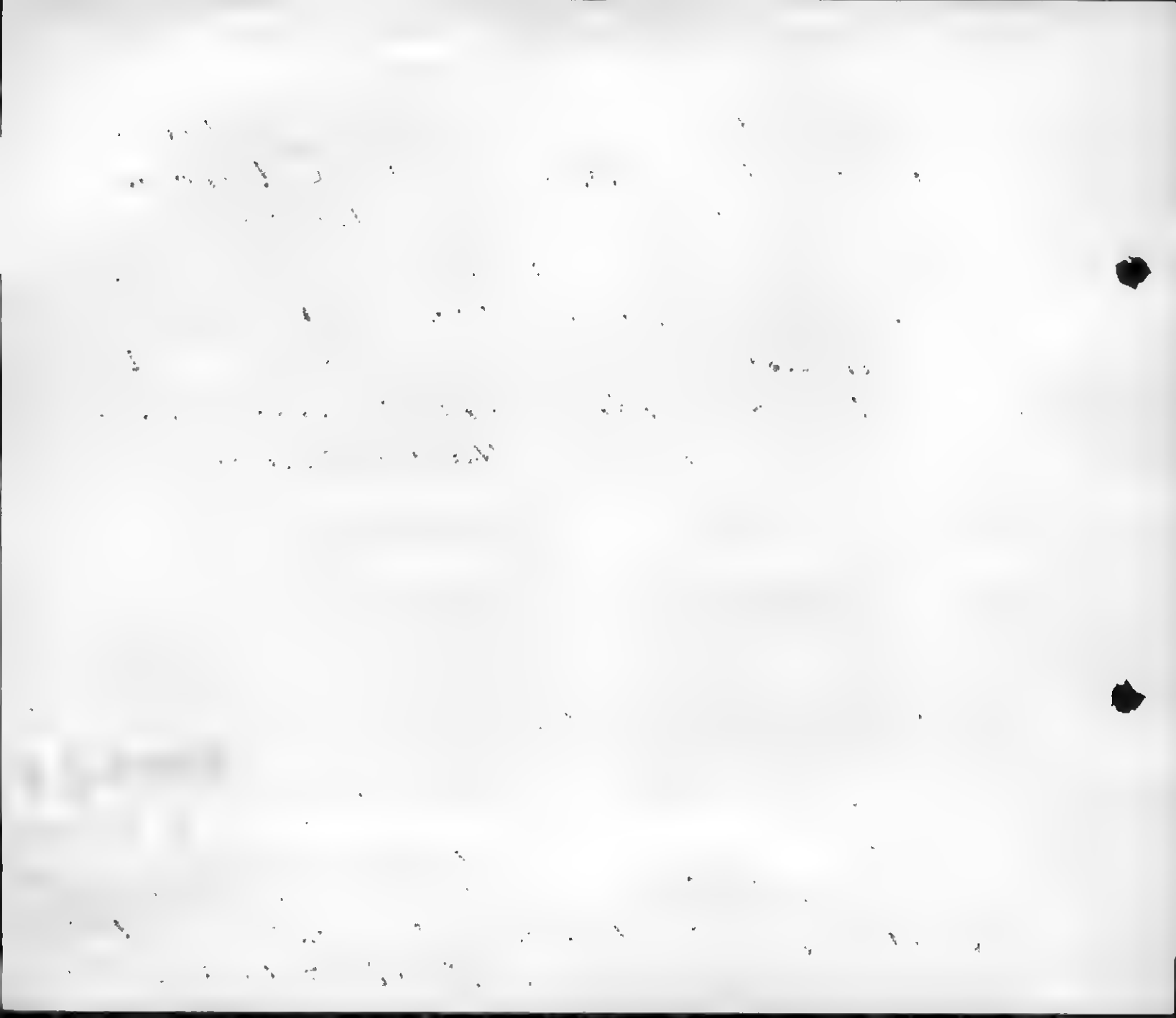
Reg. Dist. No. 131

8680

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>HOWARD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Woodbine</u>			
TOWN <u>Frederick</u>		<u>7 days</u>		STREET ADDRESS (If rural give location) <u>Daisy 174-21</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Mem</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>IRENE E. MARTIN</u>				<u>Sept 20, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>11-11-1873</u>	
9. AGE last birthday: <u>81</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housework</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>home</u>			
13. FATHER'S NAME: <u>LENOX MARTIN</u>				14. MOTHER'S MAIDEN NAME: <u>RACHEL BRANDENBURG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>NO</u>				16. SOCIAL SECURITY NO.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>463X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
9.4.2.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture Neck of Femur - left</u>						8 days	
19A. DATE OF OPERATION: <u>Sept 19, 55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Fracture Neck of Femur.</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.) <u>HOME</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>Woodbine</u>		(County) <u>12</u> (State) <u>Md</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept 13 1955 P.M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fall at home</u>			
22. I hereby certify that I attended the deceased from <u>Sept 13, 1955</u> , to <u>Sept 20, 1955</u> , that I last saw the deceased alive on <u>Sept 20, 1955</u> , and that death occurred at <u>6:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John M. Cullen</u>		ADDRESS <u>M. D. 15E Second St NE</u>		DATE SIGNED <u>Sept 20 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		LOCATION (City, town, or county) <u>Montg. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>22 Sept 1955</u>		REGISTRAR'S SIGNATURE <u>Frank R. Smith, Jr.</u>		24. FUNERAL DIRECTOR <u>E. M. Waltz, Winfield</u>		ADDRESS <u>Md.</u>	



8712

CERTIFICATE OF DEATH

Reg. Dist. No. 139.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland COUNTY Washington			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Cullen, Maryland.		10 days		OR TOWN Hagerstown		21-03-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hosp.				STREET ADDRESS (If rural give location) 417 Brewer Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Isaac Holland Martin				9 9 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWER <input checked="" type="checkbox"/>		8. DATE OF BIRTH: 11/15/1890	
9. AGE last birthday 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical				10B. KIND OF BUSINESS OR INDUSTRY: Electric lineman		11. BIRTHPLACE (State or foreign country): West Virginia	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: Daniel Martin				14. MOTHER'S MAIDEN NAME: Agnes Fuller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Isaac H. Martin 417 Brewer Ave., Hagerstown, Maryland.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary tuberculosis						3 months	
DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from 8/30/1955 , to 9/9/55 , that I last saw the deceased alive on 9/9/1955 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.							
SIGNATURE J. B. Lynn				ADDRESS M.D. Cullen, Maryland.		DATE SIGNED 9/9/55	
23. BURIAL, CREMATION, EMBALM, SPECIFY		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/12/1955		Rest Haven Cemetery		Hagerstown, Maryland.	
DATE REC'D BY LOCAL REGISTRAR 9/9/55		REGISTRAR'S SIGNATURE J. B. Lynn		24. FUNERAL DIRECTOR		ADDRESS	
				Rest Haven Funeral Chapel, Inc.		1601 Penn. Ave., Hagerstown, Md.	

MARGIN RESERVE FOR BINDING

WILSON A. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick - Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) Montevue			
3. NAME OF DECEASED: (First) (Middle) (Last) VALENTINE E. McCLEERY				4. DATE OF DEATH: (Month) (Day) (Year) September 26, 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Sept. 14, 1888	9. AGE last birthday: 67 yrs.	10. UNDER 1 YEAR: Months Days Hours Min.	11. UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: Perry B. McCleery				14. MOTHER'S MAIDEN NAME: Jane E. Doub			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mr. Edward D. Storm, 114-A West Church Street, Frederick, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE (A) Chronic myocarditis						3 yrs.	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 25, 1955 , to Sept. 25, 1955 , that I last saw the deceased alive on Sept. 25, 1955 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE H. J. Keene		M. D. Frederick, Maryland		DATE SIGNED 9/28/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 29, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR Sept. 29, 1955		REGISTRAR'S SIGNATURE Elizabeth B. Herb		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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LIBRARY U.S.

8713

CERTIFICATE OF DEATH

Reg. Dist. No. 139 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cullen</u>		<u>126 days</u>		OR TOWN <u>Frederick</u> //			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Victor Cullen State Hospital</u>				STREET ADDRESS (If rural give location) <u>121 East Third Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Ethel Knott Mercier</u>				<u>Sept. 9, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 Hrs. Days	IF UNDER 24 Hrs. Hours Min.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Aug. 31, 1885</u>	<u>70</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housewife</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>David V. Knott</u>				<u>Frances Weaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u> (If Yes, give war or dates of service)		<u>218-34-3643</u>		<u>Patient at above address.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of ovary</u>						<u>4 months.</u>	
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(occx)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Tuberculosis</u>						<u>6 months.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 6, 1955</u> , to <u>Sept. 9, 1955</u> that I last saw the deceased alive on <u>Sept. 9, 1955</u> , and that death occurred at <u>7:00 M.</u> from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>Edward P. Ritchie</u>				<u>Cullen, Maryland</u>		<u>September 9, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-12-55</u>		<u>Mt. Olivet Cem.</u>		<u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9/9/55</u>		<u>[Signature]</u>					

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08701

8682

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY Frederick MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick-Rural RD#5 LENGTH OF STAY (in this place) Since 11/26/49		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick // STREET ADDRESS (If rural give location) 106 East Street	
3. NAME OF DECEASED: (First) WILLIAM (Middle) HENRY (Last) MILLBERRY		4. DATE (Month) (Day) (Year) OF DEATH September 22, 1955	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 24 May 1870
9. AGE last birthday 85 yrs.		10. UNDER 1 YEAR: Months 0 Days 0	11. UNDER 24 HRS.: Hours 0 Min. 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Coal Company	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Wesley Millberry	
14. MOTHER'S MAIDEN NAME: Rachel Gaylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-09-7045A		17. INFORMANT & ADDRESS: 210 12th St., Mrs. Alice Killgo, McKeesport 4, Pa.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) Chronic myocutitis DUE TO (B) Arterio sclerosis DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 3 yrs.
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1952 to Sept 6, 1955 , that I last saw the deceased alive on Sept 6, 1955 , and that death occurred at 8:05A M, from the causes and on the date stated above. SIGNATURE A. F. McLean ADDRESS Frederick, Maryland DATE SIGNED 23 Sept 1955 M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 26 Sept 1955	
NAME OF CEMETERY OR CREMATORY Fairview Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 24 Sept		REGISTRAR'S SIGNATURE Frank R. Smith, Jr.	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	



8683

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>Months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>411 Lee Place</u>	STREET ADDRESS (If rural give location) <u>27 East Fifth Street</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES RUSSELL MILLER</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>September 27, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED <u>Married</u> WIDOWED <u>Widowed</u> (Specify):	8. DATE OF BIRTH: <u>November 16, 1880</u>
9. AGE last birthday: <u>75</u> yrs.		10. DATE OF DEATH: <u>September 27, 1955</u> IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Brick Works</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles W. Miller</u>		14. MOTHER'S MAIDEN NAME: <u>Charlotte Sheffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-2831</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Mollie D. Miller, Frederick, Maryland</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Heart Failure</u>		<u>3 months</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>		<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Cardiovascular Disease</u>		<u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Embolism</u>		<u>1 month</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1954</u> , to <u>27 Sept., 1955</u> , that I last saw the deceased alive on <u>27 Sept., 1955</u> , and that death occurred at <u>7:50A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Thomas C. Stone</u>		M. O. <u>Frederick, Maryland</u>	
DATE SIGNED <u>9/28/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 30, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>29 Sept. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hech</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

08703

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

8624

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Clark Place</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Nelson</u> (Last)	4. DATE OF DEATH (Month) <u>Sept.</u> (Day) <u>23</u> (Year) <u>1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 23, 1905</u>
9. AGE last birthday <u>50</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Unknown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
880 Immediate cause (a) <u>Coronary artery disease</u>		<u>5 hrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Frederick</u> (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Interment</u>	<u>9/27/55</u>	<u>University of Md.</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>27 Sept. 1955</u>	<u>Elizabeth B. Herb</u>	<u>Abraham E. Hicks III</u>	<u>Fred. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10-11-12

10-11-12

10-11-12

10-11-12

10-11-12

10-11-12

8685

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY Frederick MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland
 OR 11 Frederick, Maryland LENGTH OF STAY (in this place) 2 weeks
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 Frederick Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll
 (If outside corporate limits, write RURAL and give nearest town)
 OR 11 Mt. Airy, Maryland
 TOWN 06X-2
 STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

(Type or Print)

NormaFNicodemusOF DEATH: September 6, 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

9. AGE last birthday: 72 yrs.

IF UNDER 1 YEAR: Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife10b. KIND OF BUSINESS OR INDUSTRY: Own Home11. BIRTHPLACE (State or foreign country): Maryland12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Francis Engle

14. MOTHER'S MAIDEN NAME:

Ida M. Lewis15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Mr. M. L. Nicodemus, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

176X
Immediate cause(a) Carcinoma of Uterus

DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) Metastases to Bladder and Rectum

DUE TO

(c)

Interval Between Onset And Death

5 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

Jan 1951

19b. MAJOR FINDINGS OF OPERATION

Carcinoma of body of Uterus

20. AUTOPSY ?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 8/25, 1955, to 9/6, 1955, that I last saw the deceased alive on 9/6, 1955, and that death occurred at 4:25 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, (Specify)

Burial

DATE THEREOF

Sept. 9, 1955

NAME OF CEMETERY OR CREMATORY

Pine Grove

LOCATION (City, town, or county)

Mt. Airy,Md.

DATE REC'D BY LOCAL REGISTRAR

8 Sept. 1955

REGISTRAR'S SIGNATURE

Elizabeth G. Heck

24. FUNERAL DIRECTOR

Oliver L. Molesworth, Damascus, Md.

MARGIN RESERVED FOR INDEXING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 131

8714

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN Adamstown				OR TOWN Adamstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
LEWIS EDWARD OGLE				September 10, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widower	October 31, 1886	68 yrs	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Retired Station Agent-B.&O.R.R.						Maryland	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John H. Ogle				Rebecca Medairy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
Yes				Mrs. Mary Scarff, Adamstown, Maryland			
16. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) Coronary occlusion			
ANTECEDENT CAUSE (B)				(B) Hypertensive - arteriosclerotic heart disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March, 1957 , to 9/10, 1955 , that I last saw the deceased alive on 6/18, 1955 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
SIGNATURE James B. Thomas				M. D. Frederick, Maryland		DATE SIGNED 9/12/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 13, 1955		Mount Olivet Cemetery		Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 13, 1955		Elizabeth B. Hecker		M. R. Etchison & Son		Frederick, Maryland	

MARGIN RESERVED FOR BINDING

WILLIAM A. S.

SEP 1

CERTIFICATE OF DEATH

Reg. Dist. No. 131

8715

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick MARYLAND		STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Nr. Frederick 2 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Nr. Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D. # 4		STREET ADDRESS (If rural give location) R. F. D. # 4	
3. NAME OF DECEASED: (First) (Middle) (Last) BESSIE SHAW ROBERTS		4. DATE OF DEATH: (Month) (Day) (Year) September 19 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: October 3, 1886
9. AGE last birthday: 68 yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own home	
11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Orson Shaw		14. MOTHER'S MAIDEN NAME: Mary Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Mr. Morris W. Roberts - Rt. 4 - Frederick, Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
331X Immediate cause (a) Cerebral hemorrhage		21 days	
Antecedent causes (s) (b) Broncho-pneumonia		7 days	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 15, 1953, to Sept. 17, 1955, that I last saw the deceased alive on Sept. 18, 1955, and that death occurred at 2:30 P.M., from the causes and on the date stated above.			
SIGNATURE (Degree or title) Bernard O. Thomas, M.D.		DATE SIGNED Sept. 20, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Sept. 21, 1955	
NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 20 Sept 1955		REGISTRAR'S SIGNATURE Frank R. Smith, Jr.	
24. FUNERAL DIRECTOR C. E. Cline & Son - Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 2 A 111111

8686

CERTIFICATE OF DEATH

Reg. Dist. No. 131 ...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	MARYLAND LENGTH OF STAY (in this place) Years	STATE Maryland COUNTY Frederick CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural give location) 800 Rosemont Avenue	
3. NAME OF DECEASED: (Type or Print) NETTIE HENRIETTA ROUGHAN		4. DATE (Month) (Day) (Year) OF DEATH: September 19, 1955	
5. SEX Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: July 30, 1894
9. AGE last birthday 61 yrs		10. IF UNDER 1 YEAR: Months Days Hours Mins. 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life) Asst. Treas. & Director		10B. KIND OF BUSINESS OR INDUSTRY: Electric Corp.	
11. BIRTHPLACE (State or foreign country): Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Edward Dubry		14. MOTHER'S MAIDEN NAME: Eliza Coutcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 215-26-2112	
17. INFORMANT & ADDRESS: Lawrence V. Roughan, Frederick, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Intracranial Hemorrhage DUE TO ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cerebral arterio-sclerosis and Hypertension DUE TO (C)			4 days 10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1948 , to 9/19 , 19 55 , that I last saw the deceased alive on 18 Sept , 19 55 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above. SIGNATURE Charles R. Conley, Jr. M.D. ADDRESS Frederick, Maryland DATE SIGNED 9/19/1955			
23. BURIAL CREMATION. REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 22, 1955	
NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 20 Sept 1955		24. FUNERAL DIRECTOR Frank R. Smith, Jr. ADDRESS M. R. Etchison & Son, Frederick, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

CHIEF OF BUREAU

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 141

8697

1. PLACE OF DEATH:

COUNTY *Frederick* MARYLAND
 CITY (If outside corporate limits, write RURAL or and give nearest town) *35 Brunnsuick* LENGTH OF STAY (in this place) *2 wks*
 HOSPITAL OR INSTITUTION OR STREET ADDRESS *5 West B*

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Pa* COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN *Sharon* 75X-3
 STREET ADDRESS (If rural, give location) *386 H Street*

3. NAME OF DECEASED:

(First) *Metta* (Middle) *E.* (Last) *Sewell*
 (Type or Print)

4. DATE OF DEATH: (Month) *9* (Day) *18* (Year) *1955*

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, or SEPARATED:

Married

8. DATE OF BIRTH:

2-14-1876

9. AGE last birthday:

79

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Germany

12. CITIZEN OF WHAT COUNTRY?

Germany

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Mr M. Sewell Sharon Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

421.4
 Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

U

19b. MAJOR FINDINGS OF OPERATION:

U

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9/13/55* to *9/14/55*, that I last saw the deceased alive on *9/13/55*, and that death occurred at *13:00* m., from the causes and on the date stated above.

SIGNATURE

DEGREE OR TITLE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

9-7-55

NAME OF CEMETERY OR CREMATORY

Loudon Park

LOCATION (City, town, or county)

Baltimore Maryland

(State)

DATE REC'D BY LOCAL REG.

Sept 4-55

REGISTRAR'S SIGNATURE

Kathryn H. Brown

24. FUNERAL DIRECTOR

C. H. Leek & Co

ADDRESS

386 H Street Md.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8-30-1964

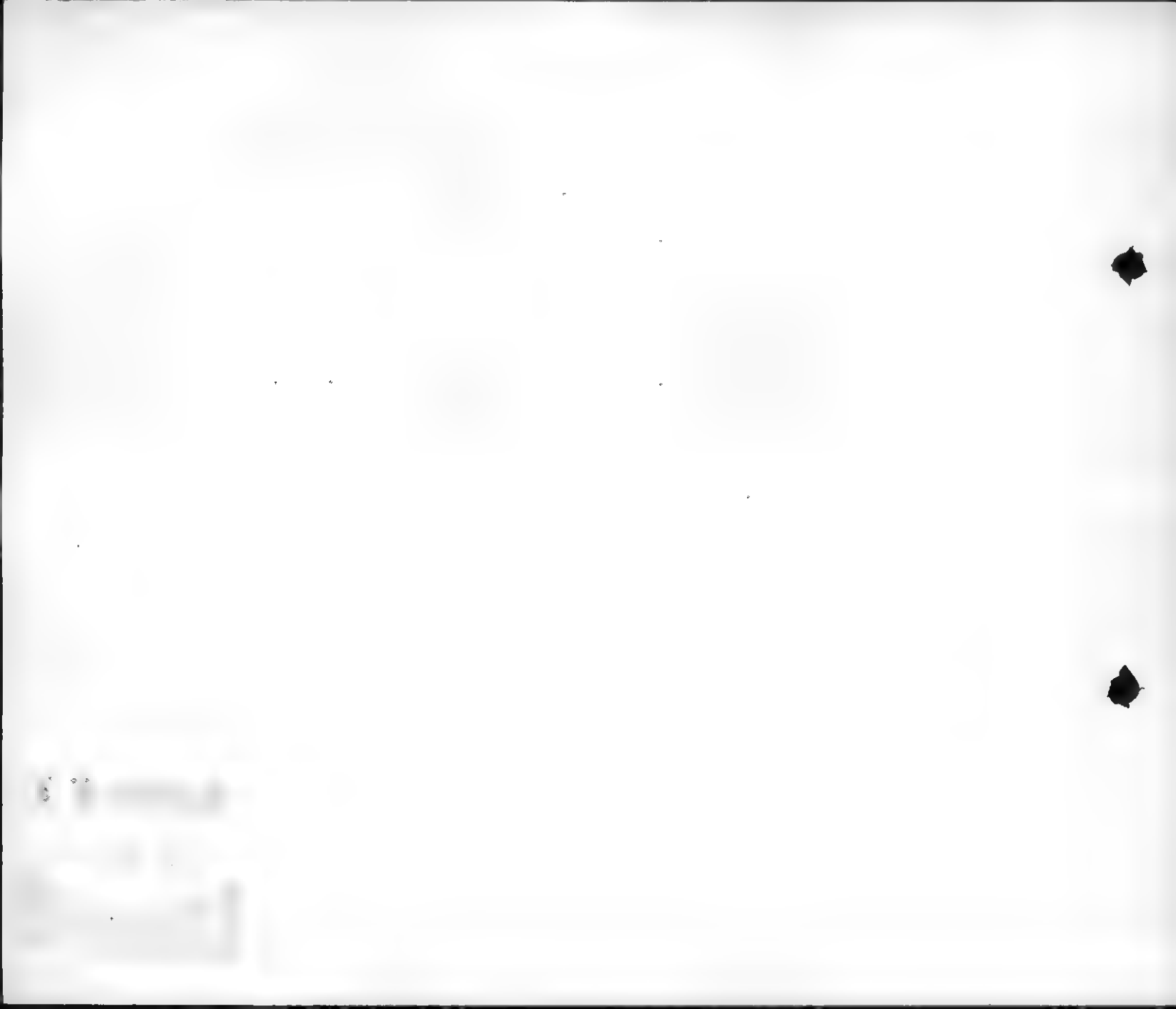
8716

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Myersville		LENGTH OF STAY (in this place) 10 min.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Myersville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Myersville, Rt. #1				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:			4. DATE OF DEATH:				
(First) (Middle) (Last) WILLIAM STARTZMAN SHEPLEY			(Month) (Day) (Year) September 17 1955				
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Male		White		Widowed		June 19, 1871	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Retired Farmer		Gen. Farming		Frederick Co. Md.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Frederick Shepley				Cynthia Pryor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no		none		Mrs. E.R. Eccard, Myersville, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.1 Immediate cause (a) Coronary Occlusion						25 Min.	
Antecedent causes (s) (b) Arterio Sclerosis							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 17, 1955 , to Sept 17, 1955 , that I last saw the deceased alive on Sept 17, 1955 , and that death occurred at 11:10 A , from the causes and on the date stated above.							
SIGNATURE J. E. Hoop MD				DATE SIGNED Sept 17 55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 20, 1955		St. Paul's Luth.		Myersville, Fred. Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 20, 1955		J. M. Bittle		Paul F. Bittle, Myersville, Md.			

MARGIN RESERVED FOR BINDING



8898

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

COUNTY

Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

HOSPITAL OR INSTITUTE OR STREET ADDRESS

110 "A" Street

LENGTH OF STAY (in this place)

10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Brunswick

STREET ADDRESS (If rural, give location)

110 "A" Street

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

William Franklin Shepherd

4. DATE OF DEATH:

(Month)

(Day)

(Year)

9

5

1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

Married

7-7-1869

86

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Frederick

Md

Reno

West Virginia

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

William Shepherd

Mary Susan Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

No

57K-14-7378A

Mr W.F. Shepherd, Brunswick Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

Coronary occlusion
Smoking

INTERVAL BETWEEN ONSET AND DEATH

rather
yes

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, or office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, to 9-5-1955, that I last saw the deceased

alive on 9-5-1955, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DECREE OR TITLE) ADDRESS

DATE SIGNED

C. H. Fubler

Brunswick Md

9-6-55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

9-7-55

Greenwood

Marville Virginia

State

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sept 6-55

Rathayn H. Brown

C. H. Fubler Brunswick Md

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8717

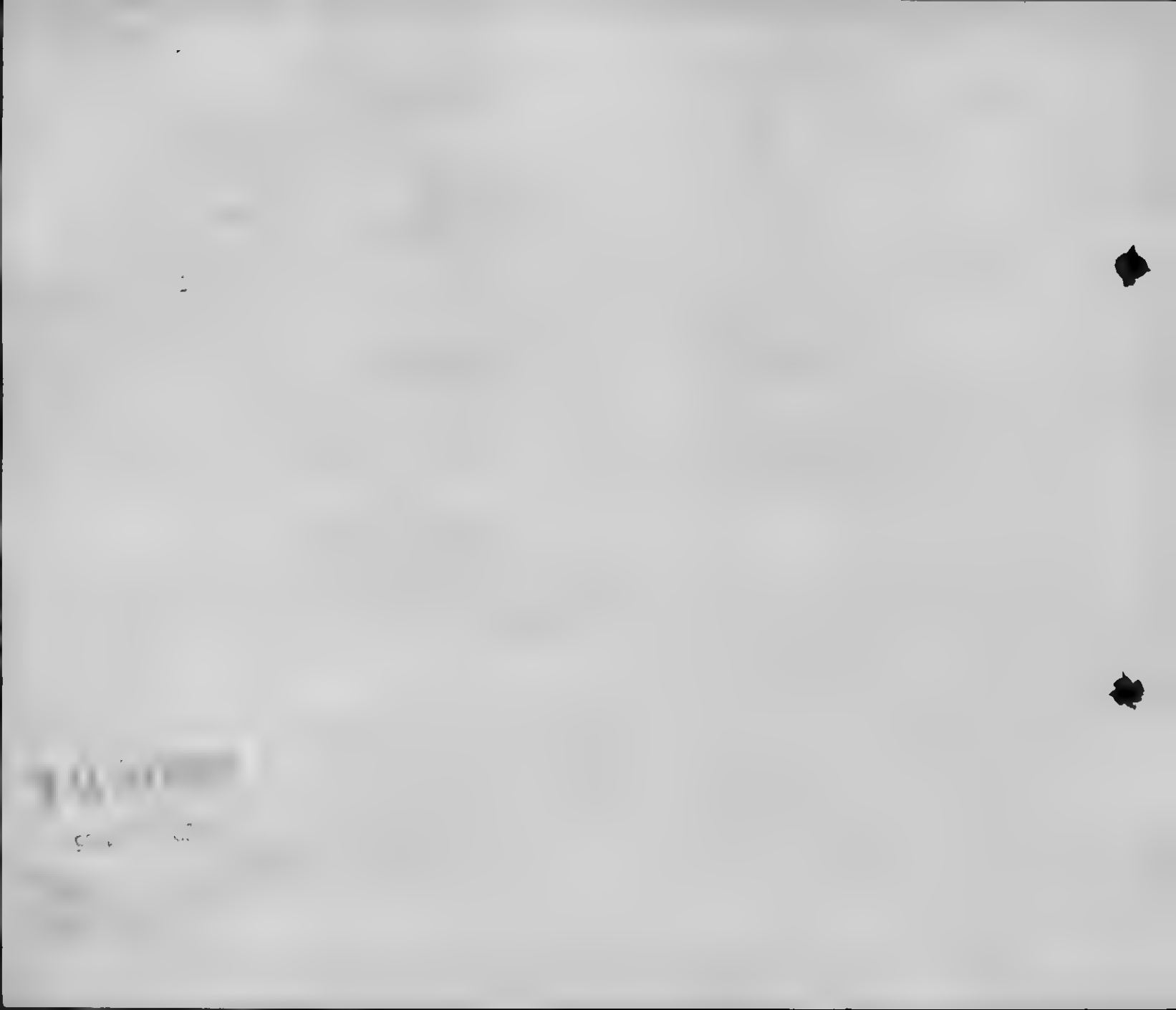
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08711

Reg. Dist.

No. 145-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Rural</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <i>Frederick</i>		<i>11</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Highway - Route 40 West</i>				STREET ADDRESS (If rural, give location) <i>125 W. Church St.</i>		<i>1</i>	
3. NAME OF DECEASED: (First) <i>Charles</i> (Middle) <i>E</i> (Last) <i>Shilling</i>				4. DATE OF DEATH (Month) <i>Sept</i> (Day) <i>23</i> (Year) <i>1955</i>			
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>SINGLE</i>	8. DATE OF BIRTH: <i>2-26-1921</i>	9. AGE last birthday: <i>34</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Day WORK</i>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Harvey A. Shilling</i>				14. MOTHER'S MAIDEN NAME: <i>Bessie May Fogle</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i> (If Yes, give war or dates of service) <i>W WART II</i>		16. SOCIAL SECURITY No.: <i>214-10-4457</i>		17. INFORMANT & ADDRESS: <i>Mrs. Bessie M. Shilling - Hagerstown - Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
816X Immediate cause		(a) <i>Broken neck, crushed bones</i>					
Antecedent cause(s)		(b) <i>rt side of face, crushed left side of chest from front to</i>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <i>ruptured rib</i>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Back of car</i>		21c. (City or town) <i>Frederick</i> (County) <i>Md</i> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Sept. 23-55 9:15 P.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Auto ran into Back Trunk & trailer</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>B. B. B. 2744</i>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>9-26-55</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		LOCATION (City, town, or county) (State) <i>Frederick - Md.</i>	
DATE REC'D BY LOCAL REG. <i>25 Sept. 1955</i>		REGISTRAR'S SIGNATURE <i>Floyd M. Bittle</i>		24. FUNERAL DIRECTOR <i>C. E. Cline & Son</i>		ADDRESS <i>Frederick - Md.</i>	



8697

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>Years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural give location) <u>321 South Market Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>CORA DELIAH SHULL</u>		OF DEATH: <u>September 1, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 9, 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. DATE OF DEATH: <u>September 1, 1955</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles M. Little</u>		14. MOTHER'S MAIDEN NAME: <u>Emma J. Heilman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>321 South Market St. Rev. Dr. Charles H. Shull, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>		<u>1 mo.</u>	
ANTECEDENT CAUSE (B) <u>260X</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 31, 1955</u> , to <u>Sept. 1, 1955</u> , that I last saw the deceased alive on <u>Sept. 1, 1955</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. A. Scarre</u>		DATE SIGNED <u>9/1/1955</u>	
ADDRESS <u>Frederick, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 3, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 Sept. 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison & Son, Frederick, Maryland</u>	

U.S. DEPT. OF JUSTICE

SEP 2 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08713

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>Years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	OR <u>Town</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>	STREET ADDRESS (If rural give location) <u>115 Record Street</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES ASBURY SIFFORD</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>September 3, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>March 16, 1878</u>
9. AGE last birthday <u>82</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John E. Sifford</u>		14. MOTHER'S MAIDEN NAME: <u>Susan A. B. Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-1900</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Elizabeth T. Sifford, Frederick, Md.</u>		18. DATE OF OPERATION: <u>Sept. 3, 1955</u>	
19. MAJOR FINDINGS OF OPERATION: <u>Arteriosclerotic heart disease</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.0</u>		<u>1 year</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) <u>Arteriosclerotic heart disease</u>	
(B) <u>Arteriosclerosis</u>		(C) <u>Chronic nephritis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1954</u> , to <u>Sept. 3, 1955</u> , that I last saw the deceased alive on <u>Sept. 3, 1955</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. A. Pearce</u>		M. D. <u>Frederick, Maryland</u> DATE SIGNED <u>9/6/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 7, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 Sept. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth W. Heck</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son</u>		ADDRESS <u>Frederick, Maryland</u>	

JOHN A. V. S.

SEP 7 1960

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08714

Reg. Dist. No. 131

8718

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
TOWN <u>Frederick</u>		TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick County Chronic Ho.</u>		STREET ADDRESS (If rural, give location) <u>6. 1 St. C. C.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>John T. Strauder</u>		<u>September 20, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>May 26-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year Months Days If under 24 hrs. Hours Min.)
<u>Domestic</u>		<u></u>	<u>49</u> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u></u>		<u>Martha Murdock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u></u>	
17. INFORMANT		<u>John T. Strauder</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic myocarditis</u>		(b) <u>Pulmonary Edema</u>	<u>3 yrs.</u>
Antecedent cause(s) (c) <u></u>			<u>5 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u></u>		<u></u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
<u></u>		<u></u>	<u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
<u></u>		<u></u>	
HOW DID INJURY OCCUR?			
<u></u>			

22. I hereby certify that I attended the deceased from Sept 22, 1955, to Sept 22, 1955, that I last saw the deceased

alive on Sept 22, 1955, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

SIGNATURE H. Kline M.D. ADDRESS Frederick Md DATE SIGNED Sept 22

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Sept 22-55</u>	<u>Fair View</u>	<u>Frederick - Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Sept. 22, 1955</u>	<u>Frank R. Smith, Jr.</u>	<u>Charles E. Hicks</u>	<u>27 Fred Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

58 1/2 100000

100000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08715

8689

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (in this place) 52 Years		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 147 West South Street			
3. NAME OF DECEASED: (First) (Middle) (Last) CLARENCE LaMOTTE STRINE				4. DATE OF DEATH: (Month) (Day) (Year) September 29, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower		8. DATE OF BIRTH: June 24, 1877	
9. AGE last birthday 78 yrs.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Messenger		10B. KIND OF BUSINESS OR INDUSTRY: Post Office Dept.		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME: Francis T. Strine			
14. MOTHER'S MAIDEN NAME: Laura Mentzer				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT & ADDRESS: 147 West South Street Mrs. Harry B. Grove, Frederick, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 600.0 Uremia						3 weeks	
ANTECEDENT CAUSE (B) Acute Pyelonephritis						4 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis Heart Disease						1 year	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. . . ., 1955, to 14 Sept, 1955 , that I last saw the deceased alive on 24 Sept., 1955 , and that death occurred at 2:20 A.M. from the causes and on the date stated above.							
SIGNATURE Thomas C. Strine		M.D. Frederick, Maryland		DATE SIGNED 10/1/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 1, 1955		NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		LOCATION (City, town, or county) (State) Woodsboro, Maryland	
DATE REC'D BY LOCAL REGISTRAR 1 October 1955		REGISTRAR'S SIGNATURE Elizabeth B. Heck		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			

BOULEVARD V. S.

8690

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN Frederick		Years		OR TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 10 West Fifth Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
MARY EDNA SWEENEY				September 23, 19 55			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 8 Oct 1887	
9. AGE last birthday: 67 yrs.		10. KING OF BUSINESS OR INDUSTRY: At Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Speaks				14. MOTHER'S MAIDEN NAME: Mary Elizabeth Sweeney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS: Stanley C. Sweeney, 10 W. 5th St., Frederick, Maryland							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONOITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of Stomach						1 year	
ANTECEDENT CAUSE (B) Arteriosclerotic Heart Disease						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Diabetes Mellitus						10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1953 , to 23 Sept, 1955 , that I last saw the deceased alive on 23 Sept, 1955 , and that death occurred at 6 PM , from the causes and on the date stated above.							
SIGNATURE Thomas E. Stone		M. D. 4 W 3rd St		DATE SIGNED 9-23-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 26 Sept 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 24 Sept 1955		REGISTRAR'S SIGNATURE Frank R. Smith Jr.		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 181

8699

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
35 <i>Brunswick</i>		35 yrs		35 <i>Brunswick</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3 Second Ave</i>				STREET ADDRESS (If rural, give location) <i>3 Second Ave</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
<i>George Franklin Taylor</i>				<i>9-16-55</i>			
5. SEX: <i>male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>7-16-1900</i>	
						9. AGE last birthday: <i>55</i> yrs.	
						IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Driver</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>134 W R R C</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>							
13. FATHER'S NAME: <i>David F. Taylor</i>				14. MOTHER'S MAIDEN NAME: <i>Betha Linda Allen</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY No.: <i>705-10-2726</i>		17. INFORMANT & ADDRESS: <i>McIsabel Taylor Brunswick Md.</i>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
572X Immediate cause (a) <i>Uremia</i>						5 days	
Antecedent cause(s) (b) <i>Bright's Disease</i>						5 yrs.	
Disenses or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>9-15-55</i>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-15-55</i> , to <i>9-16-55</i> , that I last saw the deceased alive on <i>9-16-55</i> , and that death occurred at <i>8:00 p.m.</i> from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				DATE SIGNED <i>9-17-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>				DATE THEREOF: <i>9-19-55</i>		NAME OF CEMETERY OR CREMATORY: <i>Samuels Manor Md.</i>	
LOCATION (City, town, or county) (State): <i>Brunswick Md.</i>		24. FUNERAL DIRECTOR: <i>C. H. Gills & Son Brunswick Md.</i>		ADDRESS: <i>[Address]</i>			
DATE REC'D BY LOCAL REG. <i>Sept 17-55</i>		REGISTRAR'S SIGNATURE: <i>Kathryn H. Brown</i>		24. FUNERAL DIRECTOR: <i>C. H. Gills & Son Brunswick Md.</i>		ADDRESS: <i>[Address]</i>	

MARGIN RESERVED FOR BINDING

BUREAU V. E.

SEP 20 1955

RECEIVED
SEP 20 1955
BUREAU V. E.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8692

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08718

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Fred.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Middletown</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Earl T. Tritapoe</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>9 13 1955</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	8. DATE OF BIRTH: <i>10-24-1885</i>	9. AGE last birthday: <i>69</i> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS: Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>unemployed</i>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>Samuel Tritapoe</i>				14. MOTHER'S MAIDEN NAME: <i>Lizzie Daniel</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Mrs Violet Poffenberger, Middletown, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.0</i>							
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>arteriosclerosis, generalized</i>						Year.	
(B) <i>arteriosclerotic heart disease</i>						10 year.	
(C) <i>dissecting aneurysm</i>						24 hour.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-12</i> , 1955, to <i>9-13</i> , 1955, that I last saw the deceased alive on <i>9-13</i> , 1955, and that death occurred at <i>11:10 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert S. Teunen</i>		M. D. <i>J. E. Church St. Frederick</i>		DATE SIGNED <i>9-10-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9-15-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Jefferson Cemetery</i>		LOCATION (City, town, or county) (State) <i>Jefferson Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>14 Sept. 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>		24. FUNERAL DIRECTOR <i>Shadnili Co.</i>		ADDRESS <i>Middletown Md.</i>	

BUREAU V. S.

SEP 10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808719

8691

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	LENGTH OF STAY (in this place) Years	CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural give location) 115 West Fourth Street	
3. NAME OF DECEASED: (First) (Middle) (Last) CLAYBORNE TROXELL		4. DATE (Month) (Day) (Year) OF DEATH: September 12, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower	8. DATE OF BIRTH: August 7, 1880
9. AGE last birthday: 75 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life): Retired Motorman		10B. KIND OF BUSINESS OR INDUSTRY: H. & F. Railway	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles P. Troxell		14. MOTHER'S MAIDEN NAME: Elizabeth Lohr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Mr. Charles E. Troxell, Frederick, Maryland			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) Myocardial Infarction		4 days	
ANTECEDENT CAUSE (B) Old Myocardial Infarction		5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerotic Heart Disease		5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1953 , to 12 Sept., 1955 , that I last saw the deceased alive on 12 Sept., 1955 , and that death occurred at 5:05 PM , from the causes and on the date stated above.			
SIGNATURE Thomas C. Stone		M. D. Frederick, Maryland	
DATE SIGNED 9/14/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 15, 1955	
NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 14 Sept. 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hech	
24. FUNERAL DIRECTOR M. R. Etchison & Son		ADDRESS Frederick, Maryland	

DOUGLAS V. S.

SIP 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08720

Reg. Dist. No. 131

8719

1. PLACE OF DEATH— COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE Maryland COUNTY Frederick	
3. NAME OF DECEASED (First) JOY (Middle) ATTATTE (Last) TYERYAR		4. DATE OF DEATH September 3, 1955	
5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Mar. 12, 1953	
9. AGE last birthday 2 yrs.		10. If under 1 year Months Days	
11. If under 24 hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles S. Tyeryar		14. MOTHER'S MAIDEN NAME Phyllis England	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	
17. INFORMANT AND ADDRESS Mr. Charles S. Tyeryar, Ijamsville, Maryland			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 929.0 (a) <i>Dr. [Signature]</i>		5 years, 6 months	
Antecedent cause(s) (b) <i>7</i>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		ACT OR TOWN (COUNTY) (STATE)	
Fall in pond about 11:45 A.M.		Near Habana Frederick Md	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>[Signature]</i>		DATE SIGNED 9/6/1955	
23. BURIAL INFORMATION REMOVED (Specify) Burial		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
DATE REC'D BY LOCAL REG. 6 Sept. 1955		LOCATION (City, town, or county) Frederick, Maryland	
REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	

SEP 7 1955

THESE

8720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sabillasville</u>		LENGTH OF STAY (in this place) <u>25 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sabillasville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Jane</u>		<u>E.</u>		<u>Waynant</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 11,</u> <u>19 55</u>	
5. SEX.	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Jan. 15, 1871</u>	<u>84 yrs.</u>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Store Clerk</u>		<u>Waynesboro</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>A. E. Waynant</u>				<u>Marion Bender</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>NO</u> (If Yes, give war or dates of service)				<u>Mrs. X. P. Harbaugh, Waynesboro Pa.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422-1 IMMEDIATE CAUSE							
(A) <u>Semility</u>							<u>1 yr.</u>
ANTECEDENT CAUSE (S)							
(B) <u>Arteriosclerosis</u>							<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							<u>?</u>
<u>Chronic myocarditis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 7, 1946</u> , to <u>Sept. 11, 1955</u> , that I last saw the deceased alive on <u>Sept. 10, 1955</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		<u>M. Franklin Birch</u>		M. D. <u>Thurmond Tied.</u>		DATE SIGNED <u>9/14/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/14/55</u>		<u>Green Hill</u>		<u>Waynesboro, Franklin Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>9/14/55</u>		<u>[Signature]</u>		<u>Walter Y. Grove</u>		<u>Waynesboro Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY

1955

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08722

8721

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - near Thurmont</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - near Thurmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. #1</u>		STREET ADDRESS (If rural, give location) <u>Rt. #1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MONROE</u> (Middle) <u>ELSWORTH</u> (Last) <u>WETZEL JR.</u>		4. DATE OF DEATH (Month) <u>Sept.</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 25, 1955</u>
9. AGE last birthday <u>0</u> yrs. <u>0</u> months <u>0</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Monroe Elsworth Wetzels Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Estella Mae Moser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Monroe E. Wetzels Sr. Rt. 1 Thurmont, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>7-4-4</u> <u>Congenital heart anomaly</u>		<u>4 hr. 15 min.</u>
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		
(c) <u>Other significant conditions</u> Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 25, 1955, to Sept. 25, 1955, that I last saw the deceased alive on Sept. 25, 1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

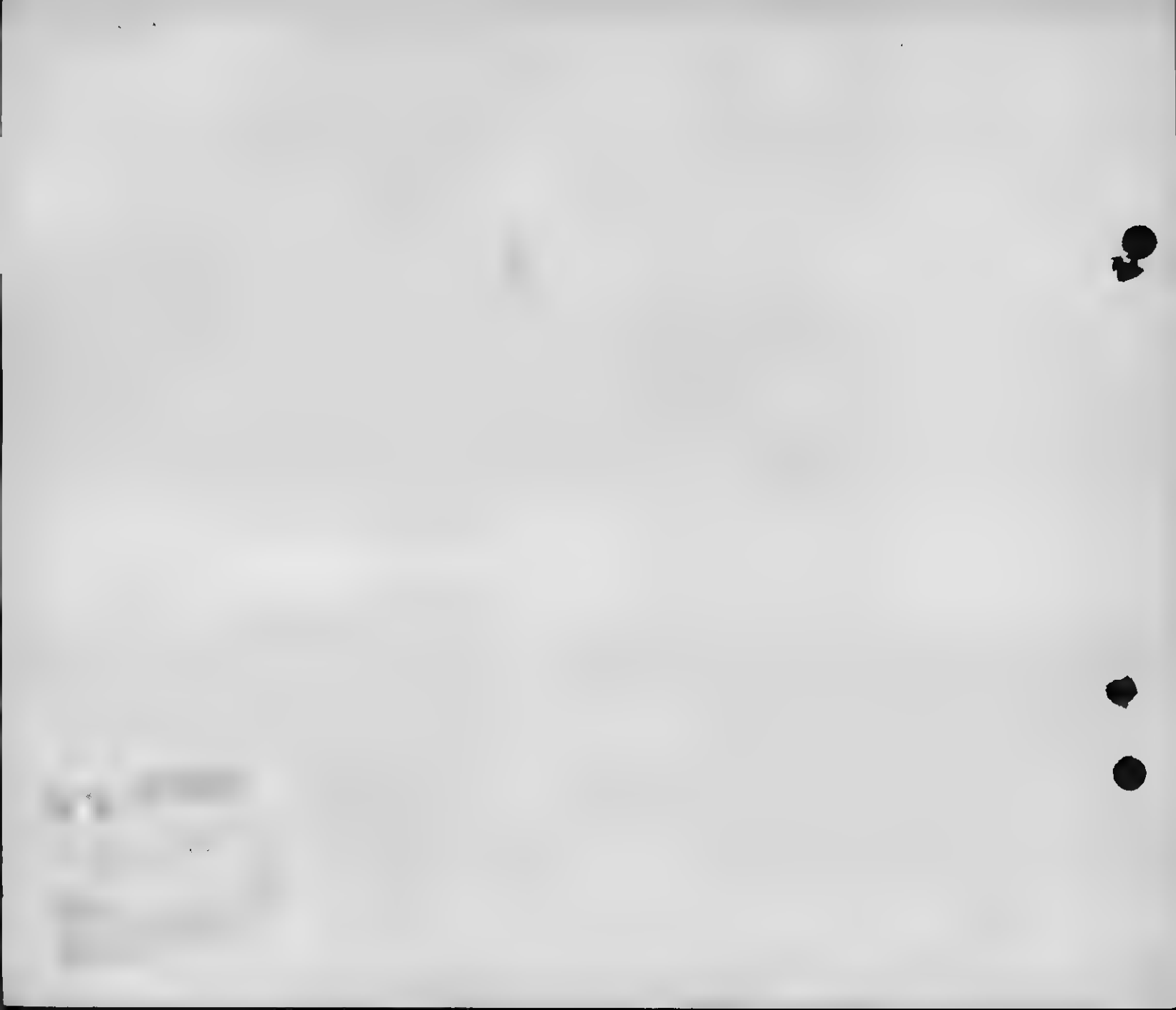
SIGNATURE M. Franklin Birch M.D. ADDRESS Thurmont, Md. DATE SIGNED Sept. 25, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Sept. 26, 1955</u>	<u>Mountain View</u>	<u>Emmitsburg</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>9/26/55</u>	<u>L. C. Powell</u>	<u>Burke & Hartzler</u>	<u>2 Woodboro Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8722

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Braddock Heights</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vindobona Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>404 West Second Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>NORINE</u> <u>WHITEHILL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>September 9 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, SEPARATED (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>July 11, 1873</u>	
9. AGE last birthday: <u>82</u> yrs.		10. MONTHS <u>11</u> Days <u>19</u> Hours <u>55</u> Min.		9. AGE last birthday: IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>Harry Douty</u>			
14. MOTHER'S MAIDEN NAME: <u>Kate Wilson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>None</u>				17. INFORMANT & ADDRESS: (son) <u>Mr. H. Webster Whitehill - Frederick, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4230 Immediate cause (a) <u>Acute pulmonary edema</u>		<u>20-30 min.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>		<u>10 yrs +</u>
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) OF INJURY		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>Dec 1953</u> , to <u>Sept. 9, 1955</u> , that I last saw the deceased alive on <u>Sept. 9, 1955</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.					
SIGNATURE		(Degree or title)	ADDRESS	DATE SIGNED	
<u>Henry V. Chase M.D.</u>			<u>4 E. Church St. Frederick Md</u>	<u>9/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>9/11/55</u>	<u>Linganore Cemetery</u>	<u>Unionville,</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>10 Sept. 1955</u>		<u>Elizabeth L. H. eda</u>	<u>C. E. Cline & Son - 8 East Patrick Street</u> <u>Frederick, Maryland</u>		

MARGIN RESERVED FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



2693

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick LENGTH OF STAY (in this place) 4 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

319 Madison Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Fred.CITY (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland

STREET ADDRESS

319 Madison Street

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

WilliamsEdwardNathan

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Sept. 2919 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleColoredSingleJan. 1, 187580yrs.MonthsDaysHoursMin.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)

Railroad

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country).

Montgomery Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Harplus Williams

14. MOTHER'S MAIDEN NAME:

Laura Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY No.

Unknown

17. INFORMANT & ADDRESS:

Odie Bell 319 Madison Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause(a)Antecedent causes (s)Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b)DUE TO(c)Interval Between Onset And Death
6 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 2-4-1955, to 9-29-1955, that I last saw the deceased alive on 9-29-1955, and that death occurred at 9:30 P, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialOct. 2, 1955St. PaulsDella, Fred. Co. Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct. 19 1955Elizabeth S. HeckCharles E. Hicks IIIFrederick, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 19 1954

100

100

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

COUNTY **Frederick** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Brunswick** LENGTH OF STAY (in this place) **37 years**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **114 \$ 4th.Ave.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Frederick**
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Brunswick**
 STREET ADDRESS (If rural, give location) **114 4th.Ave**

3. NAME OF DECEASED:

(First) **William** (Middle) **Robert** (Last) **Williams**

4. DATE OF DEATH: (Month) **9** (Day) **11** (Year) **55**

5. SEX: **Male**

6. COLOR OR **White**

7. SINGLE, MARRIED, **Married** DIVORCED, (Specify)

8. DATE OF BIRTH: **7-16-1885**

9. AGE last birthday: **65** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, **Brakeman**

10b. KIND OF BUSINESS OR INDUSTRY: **B and O.R.R.Co.**

11. BIRTHPLACE (State or foreign country): **West Virginia**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME:

Ashby Williams

14. MOTHER'S MAIDEN NAME:

Elizabeth Crimm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **No**

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: **Mrs. Betty Koogle Williams, Brunswick, Md**

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 hrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9-11-55**, to **9-11-55**, that I last saw the deceased alive on **9-11-55**, and that death occurred at **10:30 AM**, from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL CREMATION

DATE OF BURIAL (Specify): **9-14-55**

NAME OF CEMETERY OR CREMATORY **Lutheran**

LOCATION (City, town, or county) (State) **Middletown, Maryland**

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sept 12-55

Kathryn W. Brown

C.H. Feete and Bro. Brunswick, Md.

MARGIN RESERVED FOR BINDING

Y. S. YAU

SEP 1 1965

REC-100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8723

CERTIFICATE OF DEATH

08726
Reg. Dist. No. 144

1. PLACE OF DEATH: Near Smithsburg (Rural)		2. USUAL RESIDENCE (HOME) OF DECEASED: Near Smithsburg (Rural)	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN RURAL	Lifetime	TOWN RURAL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) Alvie (Middle) Sylvester (Last) Wolfe		4. DATE (Month) (Day) (Year) OF DEATH: Sept. 3 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: Oct. 22 1900
9. AGE last birthday: 54 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Frederick Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Jack Wolfe		14. MOTHER'S MAIDEN NAME: Blanche Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: 213-16-2260	
17. INFORMANT & ADDRESS: Keller Wolfe Woodsboro, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
201X IMMEDIATE CAUSE (A) Hodgskin's disease			6 mo.
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 31, 1955 , to Sept. 3, 1955 , that I last saw the deceased alive on Sept. 2, 1955 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
SIGNATURE M. J. ...		DATE SIGNED 9/3/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: Sept. 5 1955	NAME OF CEMETERY OR CREMATORY: Mt. Bethel
DATE REC'D BY LOCAL REGISTRAR: Sept. 4 1955		24. FUNERAL DIRECTOR: W. F. ...	
REGISTRAR'S SIGNATURE: Blanche S. Eyles		ADDRESS: Garfield Fredk. Md.	

SEP

RECEIVED

8694

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>		STATE <u>Md</u> COUNTY <u>Frederick</u>		OR TOWN <u>Thurmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>		LENGTH OF STAY (In this place) <u>12 hrs</u>		STREET ADDRESS (If rural give location) <u>Thurmont</u>		X	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>ESTEE BAINE ZENTZ</u>				DATE OF DEATH: <u>Sept 13 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>Nov 2, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Edwards Inspector - Westinghouse</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Frederick Co. Md</u>		11. BIRTHPLACE (State or foreign country): <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Oramus W. Zentz</u>				14. MOTHER'S MAIDEN NAME: <u>Effie M. Lohr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>372-16-0303</u>			
17. INFORMANT & ADDRESS: <u>Erna Zentz - Thurmont Md</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						3 1/2 days	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis Heart Disease</u>						1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11 AM</u> , 1955, to <u>12 AM</u> , 1955, that I last saw the deceased alive on <u>11 AM</u> , 1955, and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Stone</u>		M. D. <u>423rd St</u>		DATE SIGNED <u>9-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>United Brethren</u>		LOCATION (City, town, or county) (State) <u>Thurmont, Fred Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR <u>M. T. Craggs & Son</u>		ADDRESS <u>Thurmont, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WILLIAM V. S.

SEP 16 1955

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8695

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08728

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick	LENGTH OF STAY (in this place) 50 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 502 East Patrick Street		STREET ADDRESS (If rural give location) 502 East Patrick Street	
3. NAME OF DECEASED: (First) (Middle) (Last) MARY MARGARET JEANETTE ZIMMERMAN		4. DATE (Month) (Day) (Year) OF DEATH: September 28, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE WIDOWED MARRIED WIDOW	8. DATE OF BIRTH: 12 Dec 1858
9. AGE last birthday: 96 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		10B. KIND OF BUSINESS OR INDUSTRY: At Home	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Lewis Stull		14. MOTHER'S MAIDEN NAME: Anna Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Mrs. R. V. Stull, RD#3, Frederick, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Chronic myosarthritis		10 yrs.	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 21, 1955 to Sept 28, 1955 , that I last saw the deceased alive on Sept 21, 1955 , and that death occurred at 4 P M, from the causes and on the date stated above.			
SIGNATURE H. H. Kline		M. D. Frederick, Maryland 29 Sept 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1 Oct 1955	Zion Reformed Cemetery	Charlesville, Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
Sept. 30, 1955	Elizabeth G. Heck	M. R. Etchison & Son, Frederick, Maryland	

BUREAU V. S.

OCT 3 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8696

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08729

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (In this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location) Bloomfield			
3. NAME OF DECEASED: (First) (Middle) (Last) SUSIE EDITH ZIMMERMAN				4. DATE OF DEATH: (Month) (Day) (Year) Sept. 27, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: November 1, 1886	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas F. Haugh				14. MOTHER'S MAIDEN NAME: Ida Adelaide Eyler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Raymond A. Haugh Sr., Frederick R.D.#3, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 175X						1 yr.	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Cystadenocarcinoma of ovary with metastases							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-2-55 , 1955, to 9-27 , 1955 that I last saw the deceased alive on 9-25 , 1955, and that death occurred at 9:15AM , from the causes and on the date stated above. SIGNATURE R. R. Martin ADDRESS Frederick, Maryland DATE SIGNED 9/28/1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 30, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 29 Sept. 1955		REGISTRAR'S SIGNATURE Elizabeth G. Hark		24. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland			

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SEP 30 1955

BUREAU V. B.